ASSESSMENT REPORT FOR

THE CENTRAL AFRICAN REPUBLIC

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NOVEMBER 5 - 18, 1990

Health Financing and Sustainability

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Contract No. DPE-5974-2-00-9026-00
Project No. 936-5974-9361351
Task No. 106

Submitted to:
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S&T/H/HSD

May 13, 1992

SUMMARY

Two consultants from the Health Financing and Sustainability (HFS) Project, James Setzer and Marcia Weaver, visited the Central African Republic (CAR) between 5 and 18 November 1990 to carry out an assessment of the country's health finance situation. The assessment was carried out at the request of the A.I.D. Liaison Officer (ALO) in Bangui and the Ministry of Public Health and Social Affairs (MSPAS). The assessment was intended to provide the basis for the development of a workplan for the MSPAS health finance working group. It is anticipated that the working group will carry out the activities contained in the workplan with the assistance of a long-term advisor (LTA) in health finance who is to be fielded by HFS through a grant from the African Development Support (ADS) Project. This assessment report will follow the "Guidelines for Situation Diagnosis: Health Financing" as developed by the HFS project.

INTRODUCTION AND BACKGROUND

The Central African Republic (CAR) is a sparsely-populated country located almost exactly in the center of Africa. It is one of the poorest countries in Africa, and its health problems, as evidenced by standard health indicators (high infant mortality rate, high population growth rate, etc.), are similar to those of many countries in the region. Although largely self-sufficient in agricultural production (an estimated 85 percent of the population practices subsistence agriculture), it experienced severe economic difficulties during the 1980s. Since independence, health policy has been based upon government financing of free delivery of health services to the population. These services have been, in large part, concentrated upon curative and hospital-based activities. Large vertical programs have been created to address the major endemic diseases. The CAR is currently implementing a structural adjustment program that calls for a freeze on hiring within the public (and, therefore, health) sector. There are indications that exceptions have been made to this freeze. Basic statistics related to CAR are presented in Exhibit 1.

Exhibit 1
Central African Republic Statistics

Income per capita: $376 (U.S. Dept of State, 1989)

Population: 2.57 Million (1991 projection based on 1988 census)

Population growth rate: 2.5 Percent (World Bank, 1989)

Infant mortality: 143 per thousand (U.S. Dept of State, 1989)
(ranges from 250 in some rural areas to 135 in Bangui)

Life expectancy: 47 years (World Bank, 1989)

Principal causes of morbidity: (MSPAS, 1988)
- Malaria
- Parasitic Infections
- Diarrhea
- Respiratory Infections
- Schistosomiasis
- STD

Public sector health facilities (MSPAS, 1988):
- 3 hospitals in Bangui (1 provides only outpatient care)
- 4 regional hospitals
- 11 prefectoral or county-level hospitals
- 62 health centers
- 91 health sub-centers
- 5 leprosy treatment centers
- 189 health posts or huts
- 1 nutrition center
- 5 laboratories

As a result of the severe economic problems facing CAR and their impact on the government's ability to finance the delivery of health services, the MSPAS has begun to look for alternative means of generating resources for the sector. The Health Financing and Sustainability (HFS) Project assessment activity carried out by Setzer and Weaver builds upon a series of USAID-sponsored activities in the area of health financing in the CAR.

Preliminary studies carried out by Levin and Weaver in 1987 for the REACH project addressed the question of patients' willingness to pay for services and recommended that the MSPAS organize a workshop on cost recovery for policymakers, and create a working group within the MSPAS to coordinate activities leading to a pilot test of cost recovery methods in the health sector. A sectoral study carried out by the World Bank in 1988 identified the difficult financial situation within the health sector.

In 1988, another REACH consultant, Dr. C. Leighton, prepared a plan for the health financing workshop mentioned above. The workshop was conducted with the assistance of several REACH consultants in April 1989. The workshop was instrumental in establishing a consensus among government ministries, political leaders, and donors for defining procedures leading to a redefined partnership for financing health care in the CAR. The seminar recommended several analyses to be conducted in order to complement existing information. These included an analysis of the cost of meeting the population's health needs and the capacity of each of the partners to respond to those needs. The seminar also recommended the creation of a MSPAS working group to coordinate those activities. Following this workshop, the MSPAS requested that USAID provide a long-term technical advisor (LTA) to work within the ministry to assist the working group with these analyses and with the development of a cost recovery system for the health sector.

RESULTS AND FINDINGS

The results presented in this report follow the "Guidelines for Situation Diagnosis: Health Financing" developed by the HFS Project. A copy of these guidelines is attached in Appendix 1.

It was not possible, during the course of the assessment trip, to collect all of the data required to provide detailed information and a complete analysis of each topic. In addition, it was decided that it was more important to assist the MSPAS health finance working group to plan necessary data collection activities and analyses than to perform those research activities. The gaps in information exposed in the assessment report have, therefore, been used as the basis for the development of the workplan for the health finance working group and the LTA.

- **Assess government laws and policy regarding alternative delivery and financing arrangements, including information on the private sector, charging for services, insurance/Health Maintenance Organizations (HMOs) and others.**

CAR has recently received international recognition for the progressive health financing law that the government adopted in March 1989. Among other things, the law allows health facilities to retain and use their revenue for operating expenses, either by working within the context of normal public finance procedures or by establishing partial financial autonomy. The ability of local health facilities to retain and manage revenues generated will allow the MSPAS to design a mechanism for a cost recovery system that will be consistent with current policy directions towards increased decentralization in the planning and management of health services.

In April 1990, the MSPAS submitted to the president a draft law that would set fees to be charged at certain levels of health facilities. The law has not yet been adopted. The draft law proposes fixed fees for hospitalizations by patient category for the central hospitals (i.e., those in Bangui, including the Centre Pédiatrique) and the regional and prefectoral levels. Fees for hospitalizations are set on an all-inclusive, daily basis. The cost of drugs is not included, except in the case of the Centre Pédiatrique, which has been operating on a semi-autonomous financial basis for several years. The draft also sets fixed fees for outpatient consultations based upon the qualifications of the medical personnel performing the consultation. Fees to be charged for certain medical acts are also proposed. It is not clear how the proposed fees were established. No mention is made of the eventual destination of the fees collected (i.e., retained by the facility, returned to the treasury, etc.), except for the 30 percent to be distributed to medical personnel at the facilities as part of the "quote-part" or incentive system.

Copies of the 1989 law and the 1990 draft law are attached (Appendix 2 and 3, respectively). In order for these laws to become operational (if signed), it will be necessary for the MSPAS to issue a series of complementary orders and decrees. The health finance working group must perform a more complete inventory of all relevant laws and regulations in order to propose an agenda for the development of an appropriate legislative basis for the support and practice of revisions in health finance policy, including those supporting MSPAS efforts aimed at decentralization.

- **Evaluate the size and utilization of the private sector (for- and not-for-profit) in the delivery of health services to rural populations (primary, secondary, and tertiary services).**

The non-public sector in CAR is composed of three types of facilities or care:

1) missionary facilities
2) private, for-profit facilities
3) care financed by private companies for their employees (care may be provided at either an MSPAS or a private facility operated by the employer).

Currently, there are four hospitals and 21 clinics or dispensaries with beds and 57 clinics or dispensaries without beds operated by missionaries in CAR. In 1987, the missionary hospital in Yaloke had a sophisticated fee system that included fee-for-service for curative care and prepayment for maternity services and children's primary care. The Foyer de Charité in Bangui charged 500 FCFA for

an office visit that included laboratory exams and pharmaceuticals. Langley, et al. have collected more recent data on these facilities, which the health finance working group plans to include in a more comprehensive analysis of cost recovery mechanisms already in operation in CAR. Data on revenues at missionary facilities are not readily available at the central ministry level.

Little is known about either private for-profit facilities or care financed by private companies. It will be necessary to collect information on care financed by private companies from records at the Inspection du Travail, the Chamber of Commerce, and the "conventions collectives." The number of employees at the relevant facilities must also be assessed in order to gain a greater understanding of the levels of services being provided through this mechanism. Such a study has been proposed for the health finance working group.

MSPAS statistics show that the majority of health care in CAR is provided by the public sector, even though there is a considerable number of missionary and private for-profit facilities in the private sector. Private sector facilities account for 14 percent of the total 4,202 hospital beds and seven percent of the total 4,578 Central African health personnel (4,679 including expatriates). Exhibit 2 shows the number of hospital admissions (excluding maternity cases) and outpatient episodes of illness in public and private sector facilities in 1988. According to these data, only 3.5 percent of the hospital admissions and 3.4 percent of outpatient episodes of illness were treated in the private sector. Note that the World Bank (1989) reports that five percent of hospital admissions and 37 percent of outpatient episodes of illness were treated in the private sector in 1985, prior to the opening of two new public sector hospitals in Bangui that are primarily outpatient facilities.

Exhibit 2

Number of Hospital Admissions and Outpatient Episodes of Illness Treated in Public and Private Sector Facilities in 1988

Sector	Hospital Admissions	Outpatient Episodes of Illness
Public	104,683 (96.5%)	1,327,680 (96.6%)
Private	3,791 (3.5%)	46,697 (3.4%)
Total	108,475 (100%)	1,374,377 (100%)

Source: DEPS/MSPAS, "Bulletin Annuel d'Information Sanitaire Année 1988"

Exhibit 3

Number of Outpatient Office Visits per Day in Public and Private Sector Facilities 1988

Sector and Type of Facility	Outpatient Office Visits Per Day
Public	
Hospital	183
Health Center	66
Sub-Center	7
Private	
Hospital	70
Clinic or dispensary	8

Source: DEPS/MSPAS, "Bulletin Annuel d'Information Sanitaire Année 1988"

Based upon these statistics, there appears to be either considerable under-utilization of private sector facilities or considerable differences between the private and public sector in the reporting of activities. Exhibit 3 shows that the number of outpatient office visits per day is much lower in the private sector than the public sector for each type of facility. For inpatient facilities, the average occupancy rate for hospital beds is 17 percent in the private sector, compared to 50 percent in the public sector (MSPAS, 1988, p. 17). In addition, private sector facilities perform only 4 percent of radiology exams, even though 17 percent of the x-ray machines are located in private facilities (MSPAS, 1988, p. 52).

- **Analyze trends in government expenditures on health services (investment, operating, foreign exchange).**

The MSPAS benefitted greatly from a strong commitment by the Government of CAR during the period 1984-1988. The MSPAS budget in constant FCFA increased at an annual growth rate of 6 percent during that five-year period. Not only did the real amount increase during that period, but the MSPAS share of government expenditures gradually increased as well. Health's share of total government spending (including operating expenses, investments, and debt service) increased from 5.2 to 6.4 percent. Health's share of operating expenses increased from 7 to 9.3 percent, and health's share of government investments increased from 3.1 to 6.9 percent. Since the 1988 budget, overall spending has decreased significantly. This overall reduction has been felt in the health budget, although probably not to the same extent as in other sectors. This is evidenced by health's increasing percentages of both operating and investment expenses.

Budget trends during the period 1984-1990 are summarized in Exhibit 4. The World Health Organization (WHO) recommends that countries such as CAR devote 10 percent of government expenditures to the health sector. Despite this commitment, it must be noted that this level of spending (operating budget) represents only 1,128 FCFA (less than $5) per habitant for 1990. It should be noted that these figures represent budget projections and may differ significantly from actual expenditures. Reliable data on actual expenditures are not available.

Exhibit 4

Trends in CAR Government and Health Budget, 1984- 1990 (in millions FCFA)

	Operating			**Investment**		
	MSPAS	CARG		MSPAS	CARG	
1984	2 371	34 106	(7.0%)	112	3 600	(3.1%)
1985	2 539	33 332	(7.6%)	182	3 330	(5.5%)
1986	3 113	35 829	(8.7%)	141	3 702	(3.8%)
1987	3 240	36 200	(9.0%)	213	3 950	(5.4%)
1988	3 454	37 288	(9.3%)	277	4 000	(6.9%)
1989	2 926	28 202	(10.4%)	-	-	
1990	2 899	27 774	(10.4%)	259	4 450	(5.8%)

(debt service not included)

Source: World Bank, MSPAS

Bilateral and multilateral aid to the health sector averaged $10 million in annual expenditures planned for the period 1984-1988 according to the World Bank. Aid to the health sector for the 1990 budget was 32,810,000,000 FCFA (approx. $11.9 million).

It is also important to note that in CAR, the investment budget refers only to the government's budgeted expenditures, and information on the expenditures of donors are not generally centralized. The World Bank (1989) reports data on the amount budgeted by donors over the five-year period 1984-1988 that were prepared in collaboration with the Ministry of Plan's first inventory of external aid. The total amount budgeted for health was $48 million or an average of $9.6 million per year, not including technical assistance or training. An analysis of trends is not possible because of the lack of annual data.

- **Analyze resource allocation trends (hospital vs. non-hospital, personnel vs. drugs, supplies, and maintenance).**

Although the vast majority of health resources in CAR are devoted to personnel costs, there is evidence of decline in that proportion in recent years. The MSPAS reports that salaries consumed 72 percent of government operating expenditures in 1988. It is, however, encouraging to note that this percentage was down from 77 percent in 1984, and nominal expenditures for salaries decreased between 1987 and 1988. The improvement in this ratio probably reflects the effects of the structural adjustment program that limits the growth of employment in the public sector as well as a program of "Depart Voluntaire Assisté" of cash bonuses designed to encourage employees to leave the civil service. A more desirable method of improving this ratio would be to increase non-personnel expenditures. Note that the World Bank reports a similar decline in the percentage of operating expenditures allocated to personnel, but their data show salaries were 81 and 85 percent in 1988 and 1984, respectively.

The MSPAS does not currently have a personnel database that would permit an analysis of salary expenditures by type of facility. An analysis of 1988 budget data indicates that 19 percent of personnel expenditures were for curative care, 27 percent for preventive care, 43 percent for general administration (including 24 percent of the total for facilities outside of Bangui) and 11 percent for social affairs. 1988 statistics suggest that 76 percent of physicians (62 percent if expatriates are included) were posted to Bangui, where an estimated 18 percent of the population lives (1975 census). Overall, 95 percent (96) practiced in cities. Fifty-five percent (64) practiced in hospitals, and 18 percent (16) were in the administration.

According to World Bank data, of the remaining 19 percent (or $2.2 million) of the government budget for operating expenses in 1988, 71.5 percent was budgeted for curative care. This percentage represents an increase from 59 percent in 1984, due in part to the operating costs of new hospitals in Bangui. Over this period, the percentage allocated to each of the other categories decreased. Most alarming were decreases from 22 to 19 percent for pharmaceuticals and from 10 to three percent for preventive medicine. Similarly, at least 90 percent of expenditures for curative care are for facilities in Bangui, leaving a total of only $156,000 (non-personnel) for all facilities outside of Bangui.

The same concentration of resources in the areas of curative and hospital care (especially in Bangui) is seen when analyzing multilateral and bilateral aid. During the period 1984-1988, 69 percent was budgeted for curative care, and 83 percent was for facilities in Bangui. It is not clear that this apparent concentration of resources in urban areas reflects the stated policies of many of the major donors for assistance to the health sector.

- **Assess degree of decentralized decision making, resource control, and planning.**

As a step toward the production of a national health development plan for 1991-1996, the MSPAS produced local and regional health plans ("micro-plans"). At the same time, the MSPAS at the central level has begun to redefine its policies and strategies in the health sector. It is planned that the integration of these central policies and strategies and the local and regional plans will allow the MSPAS to clearly articulate national goals and priorities. This process, which has been carried out with technical assistance provided by WHO,

represents an opportunity for the MSPAS to vastly increase the role played by local and regional administrative personnel in the planning and management of health programs.

The current allocation of resources in the health sector is the result of a highly centralized process not unlike those found in other Francophone African countries. Personnel, which accounts for between 70 percent and 80 percent of the operating budget, are posted by the central ministry. The ministry does not maintain a database on personnel that would permit an analysis of the current distribution of health manpower. Available information suggests that inequities exist between urban (especially Bangui) and rural areas (see above). There seems to be little or no local involvement in decisions regarding personnel allocations.

There currently exists within the MSPAS a commitment to the local retention and management of revenues to be generated through the implementation of any cost recovery mechanism. The health finance law passed in 1989 (see Appendix 2, "Article 5") provides the legal basis to allow for the retention of revenues at the local level. The Centre Pédiatrique and all maternities in Bangui have operated on a semi-autonomous basis for several years (personnel costs are still provided by the central ministry). The CAR has already had a variety of experiences with cost recovery and local management of funds. These experiences were catalogued by Langley, et al. in 1989 and will require further analysis to provide insight into the means by which the MSPAS will encourage community participation in the management and financing of health activities. Village-level development institutions exist in some areas.

Unfortunately, there is probably little experience among health personnel in either decision making or resource management at the local level. It seems clear that a system that devotes between 70 percent and 80 percent of its operations budget to personnel leaves little room for great amounts of decision making or resource management at any level. This would indicate that training and supervision will be required if the MSPAS is to follow through effectively on its plans for decentralization and cost recovery.

- **Establish extent of social financing arrangements, public or private insurance, prepayment, HMOs, and other managed care.**

The only major social financing arrangement is the Central African Social Security Office (OCSS), and it covers only a limited range of health care. Every private employer must register with the OCSS and pay a tax equal to 18 percent of workers' salaries. The worker contributes a tax equal to two percent of his/her salary (the economic incidence of the tax is not known) for a total of 20 percent of the salary. The OCSS administers a large amount of funds; revenue was $11.8 million and expenses were $11 million in 1985. The contributions finance the "allocations familiales", retirement, and half of a worker's salary during maternity leave. In the case of a work-related accident, the OCSS pays a benefit to replace the worker's salary during the time that s/he is unable to work, as well as expenses for pharmaceutical and medical care.

Employers who register with the OCSS must also establish a "convention collective" that states the terms under which the employer will provide health

care benefits for the employees. For example, the "convention collective" for the U.S. Embassy specifies that the Embassy pays 80 percent of the medical expenses of its employees and immediate families, and the employee pays the remaining 20 percent.

Companies with more that 30 employees are required to have an on-site medical staff person at the firm. In some cases, a physician in the civil service will work at the private company for one to three days a week, and receive a salary from the private company. In other cases, a nurse may be employed full-time at an on-site clinic. The physician is required by law to submit 20 percent of his/her private salary to the State, but ministry officials indicate that the law in this area is not systematically or rigorously applied.

Civil servants, who are not covered by the OCSS, pay a total of 10 percent of their base pay to a treasury-operated pension fund on a quarterly basis.

In theory, the State pays for 80 percent of the medical expenses incurred by civil service employees and the employee pays the remaining 20 percent. Ministry officials acknowledge that the State has never paid its share to facilities or the MSPAS, but feel that the 20 percent co-payment was regularly collected from employees. It is not clear whether all types of care are included in this policy.

- **Collect and review documents, papers, or research on health financing-related topics.**

The following documents were collected and reviewed during the assessment trip. Copies of these documents have been filed with the HFS information center located in the project offices. Copies have also been made and given to the ALO/Bangui.

Bossert, T. J., "Can They Get Along Without Us? Sustainability of Donor-Supported Health Projects in Central America and Africa," Social Science and Medicine, 30, no. 9, (1990) pp. 1015-1023.

Commissions des Journées de Concertation et Planification du Processus de Formulation d'une Politique Pharmaceutique Nationale, "Compte Rendu," (October 1990).

CREDES, "Projet Renforcement Institutionnel du MSPAS et Etude du Secteur Pharmaceutique," CREDES Project Proposal, (1990).

Langley, P., B. Tiotsop, and J. Gbedo, "La Sante à la Portée de la Femme et de l'Enfant : Expériences en SSP et Propositions pour l'Iniative de Bamako en RCA," UNICEF Report, (June 1989).

Leighton, C., "Trip Report: Plan for Health Financing Workshop Central African Republic," REACH Report, (August 1988).

Leighton, C., "Health Sector Financing Analysis in the Central African Republic: Report on a Planning Mission," REACH Report, (March 1990).

Leighton, C., "Scope of Work for a Health Financing Advisor in the Central African Republic," REACH Scope of Work, (March 1990).

Levin, A. and M. Weaver, "Cost Recovery in Central African Republic: Results from Two Preliminary Surveys and Selected Interviews," REACH Report, (September/October 1987).

Lombilo, G., "Briefing des Partenaires du Ministère de la Santé Publique et des Affaires Sociales sur l'Elaboration du Projet du Plan National de Dévéloppement Sanitiare 1991-1995 en République Centrafricaine," MSPAS Cabinet Report, (November 18, 1990).

Makinen, M., D. Graybill, and A. Percy, "Proceedings from the Workshop on Health Care Financing in the Central African Republic," REACH Report, (April 1989).

Makinen, M., D. Graybill, and A. Percy, "Politique de Financement et Prestations des Soins en République Centrafricaine," REACH Background Document for the Workshop on Health Care Financing in the Central African Republic, (April 1989).

Ministère de la Santé Publique et des Affaires Sociales, Direction Générale de la Santé Publique, "Micro-Plan Régional des Soins de Santé Primaires de la Région Sanitaire No. 3," (September 1990).

Ministère de la Santé Publique et des Affaires Sociales, Direction de la Médecine Préventive et de Lutte Contre les Grandes Endémies, Programme National de Lutte Contre le SIDA, "Le Point de la Lutte Contre le SIDA en République Centrafricaine," (September 1990).

Ministère de la Santé Publique et des Affaires Sociales, Direction Générale de la Santé Publique, "Micro-Plan Régional des Soins de Santé Primaires de l'Ouham," (August 1990).

Ministère de la Santé Publique et des Affaires Sociales, Direction Générale de la Santé Publique, "L'Expérience de la République Centrafricaine en Planification et Management des Soins de Santé Primaires," (August 1990).

Ministère de la Santé Publique et des Affaires Sociales, "Programme Cadre Pour l'Accélération de la Mise en Oeuvre des Soins de Santé Primaires en République Centrafricain," (January 1989).

Ministère de la Santé Publique et des Affaires Sociales, Direction des Etudes, de la Planification et des Statistiques, Services des Statistiques et de l'Information Sanitaire, "Bulletin Annuel d'Information Sanitaire Année 1988", (1988).

Pasnik, F., "Feasibility Study for the Implementation of a System of Household Contribution to Health Financing: Central African Republic," REACH Report, (September 1987).

Présidence de la République Centrafricaine, "Projet de Décret No. 90 Portant Tarification des Prestations des Etablissements Publics de Santé en République Centrafricaine."

Présidence de la République Centrafricaine, "Loi No. Fixant les Principes Généraux Relatifs à la Santé Publique en République Centrafricaine," (March 1989).

Raleigh, J., C. Peignot, and A. Lo., "External Evaluation of the ACSI-CCCD Project in the Central African Republic," Atlantic Resources Corporation Report, (August 1990).

United States Department of State, Bureau of Public Affairs, "Central African Republic," Background Notes, (November 1989).

World Bank/Department of West and Central Africa/Division of Population and Human Resources, "Analyse des Contraintes Sectorielles et des Sources de Financement du Secteur Santé en République Centrafricaine," World Bank Report, (February 1989).

World Bank, "Mission de Preparation d'un Projet de Reforme du Secteur Socio-Sanitaire," World Bank Aide Memoire, (December 1989).

- **Summarize efficiency problems and gaps in knowledge.**

The assessment mission did not address the efficiency of the health care delivery system in CAR. With the installation of a cost recovery system, it will be essential for the system to deliver services at the least cost possible without compromising the quality of those services. At that time, the efficiency of the system (including the procurement and distribution of drugs and other pharmaceuticals) must be addressed. It is clear from these discussions that the apparent low productivity of the private sector and skewed government expenditures (toward hospitals, curative care, and personnel costs) are major questions that must be addressed.

A number of major gaps in knowledge have been identified. They have been incorporated into discussions of the action plan for the MSPAS health finance working group.

It will be necessary for the health finance working group to perform a more complete inventory of all relevant laws and regulations in order to propose an agenda for the development of an appropriate legislative basis for the support and practice of revisions in health finance policy.

Little is known about either private for-profit facilities or care financed by private companies. It will be necessary to collect information on care financed by private companies from records at the Inspection du Travail and Chamber of Commerce on the "conventions collectives" and the number of employees at the relevant facilities to gain a greater understanding of the levels of services being provided through this mechanism.

An analysis of trends in government and donor expenditures in the health sector is not possible because of the lack of annual data. A study of this area will be necessary to provide a complete picture of resource allocation. Higher priority could be placed on the development of means to improve future allocations.

Although anecdotal evidence suggests that current household expenditures for health services are quite high, a study of expenditures will be important to allow the MSPAS to fix appropriate fee levels as well as design an equitable system for granting waivers and exemptions. The ability of the population to participate in the financing of health services is a major concern of the MSPAS.

Little is known about the operation of the pharmaceutical sector in CAR. The ability of this sector to provide health facilities with a stable supply of essential drugs at minimal cost is at the heart of the MSPAS primary health care strategy and constitutes a major challenge in the implementation of cost recovery systems.

The MSPAS must develop estimates of the cost of delivering various services. This information will be of importance in aiding the MSPAS in establishing tariff structures for certain types of services. It will also assist the MSPAS in efforts to improve the quality of services at the lowest possible cost that will accompany the implementation of cost recovery mechanisms.

- **Identify data collection, analysis, and research needs and priorities.**

Based upon the gaps in knowledge described in this report and the desire of the MSPAS to move rapidly toward a system of cost recovery, a draft workplan has been developed, using data collection, analysis, and research needs identified by the health finance working group and the HFS assessment team.

The workplan addresses the major questions contained in the recommended research agenda developed at the health financing workshop held in March 1989. It is anticipated that the activities contained in the workplan will be carried out in collaboration with a number of donor organizations. A high degree of management and coordination on the part of the MSPAS will be required if these activities are to provide a comprehensive basis for the design and implementation of a cost recovery system in CAR. A summary of this workplan follows:

1. Role of the health finance partners (government, community, donors, and private sector.

Cost of health priorities. For this activity, the workplan provides information on the cost of the health priorities identified in the regional plans and "micro-plans." This information could then be used to guide discussions on the national health strategy, so that the strategy could take into consideration the resources that would be necessary to achieve national goals. The health finance working group will review the cost estimates contained in "Costing of the Talloires Child Survival Goals: A Report to the Task Force For Child Survival" and provide a summary of relevant information from these estimates to the MSPAS.

In addition, the health finance working group will also assess whether detailed information on the cost of delivering certain services specifically in CAR will be necessary.

Capacity of partners to respond to health needs. Discussion of this activity will center on the role of donors. Among the four partners in the health

sector, the capacity of the government is already available in budget figures. The role of the community will be further defined through discussions of cost recovery. The capacity of the private sector will require further study. The MSPAS will meet with donors to learn about potential funding for the health sector, and then work with donors to develop projects that are consistent with the MSPAS national health strategy. The meetings with donors are currently planned in conjunction with the development of the national health strategy, but they may occur as a separate exercise for developing the cost recovery strategy during the upcoming year.

2. System of community participation (cost recovery methods).

Socio-economic studies. Three types of studies are recommended in order for the MSPAS to make decisions about the community's capacity to respond to health needs, and, hence, the appropriate cost recovery method for them: 1) traditional demand studies, 2) marketing studies, and 3) sociological studies. A brief discussion of each type of study is summarized in the following paragraphs.

The health finance working group will review **demand studies** that have been conducted in other countries, especially in Africa. These studies provide information on the relationship of the quantity of health care demanded to the price of health care and household income. The results from studies in other countries may be sufficient and the collection of detailed, comparable data from a demand study in CAR may not be necessary. It is important to note that detailed data on the demand for health services would be time consuming and costly to obtain. In addition, information on the relationship between demand and price may be difficult to estimate in CAR, since few facilities now charge for care and it is difficult to control for differences in the quality of care between facilities.

The type of **marketing study** recommended is a variation of traditional demand studies that would directly address the concerns of policymakers in CAR. Policymakers are concerned with questions such as what health services the population would like and how much the population is willing to pay for these services. They are interested in whether the amount that the population is willing to pay is more or less than what it is already paying for care, and what it will cost to deliver those same services. Therefore, the study will use marketing techniques to determine what services the population wants, experimental economic techniques to estimate how much the population is willing to pay for those services, and traditional methods to estimate how much the population currently spends for health care. These data will be supplemented with information on household income in order to assess the population's capacity or ability to pay for health care; capacity will be measured as the percent of income devoted to health care expenditures.

The World Bank has proposed a **socio-economic study** as part of its Social Dimensions of Adjustment project. Although the methodology to be employed in the study has not yet been finalized, it appears that it will be based upon techniques similar to those of a focus group. The health finance working group will learn more about the scope and method of the study and advise the MSPAS on

how the study can provide information that is not already available from the regional plans and "micro-plans."

Cost of services. Analyses of the cost of services can provide information on the cost of current services as well as the cost of the potentially higher-quality services that are anticipated to be available when cost-recovery is introduced. The working group will prepare cost estimates of the current services. These estimates will provide an opportunity to learn how to conduct cost studies and provide a baseline with which to measure changes when cost recovery is introduced. Any decision to undertake studies in this area must take into account the lack of reliable data for this type of analysis.

The second focus of activities in this area will seek to provide information relevant to efforts to provide high-quality services at the lowest possible cost. This analysis will be conducted in collaboration with medical personnel, who will establish standard guidelines for the treatment of patients using essential drugs. It will also include analyses of the costs of transporting and distributing pharmaceutical products to ensure a continuous supply of essential drugs to health facilities.

3. Management and implementation of the cost recovery system.

Priorities for research and analysis in this area center on operational issues linked to the introduction and operation of a cost recovery system for the MSPAS. Initial activities will address the following issues:

- Role of village-level structures in the management and accounting systems required for cost recovery,
- Development of appropriate accounting and financial information systems, and
- Systems to monitor and evaluate the operation and impact of the system.

Other research needs in this area will become apparent as the MSPAS further defines the exact nature of the cost recovery system to be developed and installed.

- **Determine the willingness of CAR to effect change, and of USAID and CAR to contribute financial, human, and logistical resources.**

All indications are that the MSPAS is ready to participate in the review and reform of health finance policy at this time. There appears to be a clear and unanimous commitment to change on the part of MSPAS personnel. The request by the MSPAS for a long-term advisor comes from their desire to establish a sufficient technical basis upon which to modify and implement policy changes. This is an excellent environment for the use of long-term technical resources (see Setzer and Weaver's HFS Trip Report of November 1990).

The questions of financial, human, and logistical resources required to support the LTA and the agenda for the revision of health finance policy have

been raised. Although there were no conclusive decisions made during the course of the HFS assessment trip, the process by which they will be resolved prior to the arrival of the LTA has been defined.

- **Assess the opportunity to leverage project resources through cooperation with other donors.**

There are several donor and NGO organizations active in the health sector in CAR. A number have expressed interest in the MSPAS's plans for cost recovery. It will be necessary for the health finance working group to play an active role in coordinating these organizations if the MSPAS is to develop a single coherent strategy for cost recovery.

There are currently a number of donors and NGOs (including missionary groups) whose projects and activities in the delivery of health services are implementing a variety of cost recovery systems. Many of the current experiences have already been described either by Levin and Weaver or a 1989 UNICEF study (see Langley, et al.) of primary care activities in CAR. The MSPAS can learn a great deal of practical information concerning the operation of a cost recovery system (including the design and operations of accounting and management systems) from these experiences. The Centre Pédiatrique, a government-run facility in Bangui, collects and manages fees with full-time French technical assistance. The MSPAS must decide the degree (if at all) to which donor and NGO-run facilities will participate in or apply the MSPAS cost recovery system.

The donor organization with the greatest interest in participating in the development and implementation of a cost recovery system seems to be UNICEF. Such a system could be an integral part of CAR's program under UNICEF's "Initiative de Bamako". UNICEF plans to propose the installation of a cost recovery system that would cover at least the cost of pharmaceuticals in 53 communes (in the prefectures of Bossangoa, Kaga Bandoro, and Bosembélé) as a first step. UNICEF would provide necessary equipment and an initial supply of drugs to the chosen facilities. An initial stock of essential drugs would be furnished to each facility and a revolving fund created from the sale of the drugs to patients at the facility. Once operational in the areas mentioned above, UNICEF would presumably choose other areas for implementation. UNICEF indicated that it expects the MSPAS to define a preliminary or indicative list of essential equipment required for each level of health facility, as well as a list of essential drugs. Another project, "Femmes, Nutrition et Développement" is being developed by UNICEF and will be implemented in the same areas chosen for the initial round of Bamako Initiative activities.

UNICEF has expressed a desire to collaborate with the health finance working group in the area of cost recovery. UNICEF has funds that could be made available to the working group for research and/or study tours to other countries already operating cost recovery systems.

Funding for a study of the current system of pharmaceutical purchasing and distribution in CAR will be provided through a loan from the African Development Bank (ADB). A contract has recently been signed with a French consulting firm,

CREDES, to provide technical assistance to the MSPAS to perform the study. The field phase of the study is scheduled to last two months. The results of this study will be very important to ensure that the MSPAS will be able to guarantee the availability of drugs as part of a cost recovery system.

In addition to the study described here, CREDES has signed a contract with the MSPAS (with funding from the ADB) to reinforce the institutional capacity of the DEPS. The contract calls for CREDES to provide an impressive number of person-months of both long- and short-term technical assistance. The proposed chief of party is an "économiste-planificateur". The SOW, as contained in the CREDES proposal, calls for the chief of party to develop a plan with the MSPAS for the installation of a cost recovery mechanism. It will require a substantial effort on the part of the DEPS and perhaps the office of the Directeur Général (DG) of the MSPAS to coordinate the activities proposed by CREDES with those contained in the workplan for the LTA and the health finance working group.

The World Bank is currently developing a loan for the health sector in CAR. Activities are being funded under an initial Project Preparation Fund (PPF). As part of this project preparation process, it will finance a complete inventory of health facilities and equipment. This inventory will, presumably, be used to develop a plan for the (re)equipment and repair of existing MSPAS health facilities. The World Bank indicated that, aside from this, it would await the creation of the national health development plan to indicate which activities it would be willing to finance through any future loans in the health sector. The World Bank supports the MSPAS in its desire to choose and implement a cost recovery system, although it does not currently have specific activities planned in this domain.

As part of its Social Dimensions of Adjustment program, the World Bank is currently planning a survey of beneficiaries in the health and education sectors in CAR. The survey will be designed to elucidate the population's desires and demand for services in these two sectors. The World Bank has already been in contact with the DEPS at the MSPAS concerning the design of the study. It will be desirable for the working group to collaborate with the World Bank on this study as well, since it will, hopefully, provide insight into the types of services desired by the population, as well as their willingness to pay for such services.

Other donors that have expressed an interest in MSPAS cost recovery activities, but have no specific activities planned in the area, are:

- Peace Corps
- French Technical Assistance (FAC)
- European Development Fund (FED)
- United Nations Fund for Population (FNUAP)

It is the opinion of the HFS assessment team that, given the interest expressed by other donor organizations in health finance issues, the opportunity to leverage project resources through collaboration is extremely high. The MSPAS has expressed its desire for increased donor collaboration in this area. The articulation of policy in this area and the completion of technical activities related to its operations will orient donor activities along a common path. This

will be an important step in the development and evolution of the health system in CAR. The placement of the health finance working group within the office of the MSPAS Director General will facilitate this collaboration as well.

CONCLUSIONS

The CAR appears quite ready and willing to undertake the redefinition of its health finance policy. Interest on the part of the MSPAS and the principal donor organizations operating in the country is high. Important gaps in knowledge about the health sector in CAR have been identified. These gaps will be addressed through an aggressive and pragmatic program of technical assistance and applied research leading to the design and implementation of a cost recovery system for health services in CAR. Interest in the implementation of such a system is high. Discussions are currently under way that will affirm cost recovery as an integral part of an overall statement of policy and strategy for the health sector.

ABBREVIATIONS

ADB	African Development Bank
ADS	African Development Support
ALO	A.I.D. Liaison Officer
CAR	Central African Republic
DG	Directeur Général
FAC	French Technical Assistance
FED	European Development Fund
FNUAP	United Nations Fund for Population
HFS	Health Financing and Sustainability
HMO	Health Maintenance Organization
LTA	Long-Term Advisor
MSPAS	Ministry of Public Health and Social Affairs
NGO	Non-Governmental Organization
OCSS	Central African Social Security Office
PPF	Project Preparation Funds
REACH	Resources for Child Health
SOW	Scope of Work/Statement of Work
STD	Sexually Transmitted Disease
WHO	World Health Organization

APPENDIX 1

Guidelines for Situation Analysis: Health Financing

EXHIBIT 2

GUIDELINES FOR SITUATION DIAGNOSIS: HEALTH FINANCING

- Assess government laws and policy regarding alternative delivery and financing arrangements: private sector, charging for services, insurance/HMO, and others.
- Evaluate the size and utilization of public and private (for- and not-for-profit) sectors in the delivery of health services (to rural and urban populations; primary, secondary and tertiary services).
- Analyze trends in government expenditures on health services (investment, operating, foreign exchange).
- Analyze resource allocation trends (hospital vs. non-hospital personnel vs. drugs, supplies, and maintenance).
- Summarize efficiency problems and gaps in knowledge.
- Assess degree of decentralized decision making, resource control, planning.
- Establish extent of social financing arrangements, public or private insurance, prepayment, HMOs, other managed care.
- Collect and review documents, papers, or research on health financing related topics.
- Identify data collection, analysis, and research needs and priorities.
- Determine the willingness of host country to effect change, and of USAID and the host country to contribute financial, human, and logistical resources.
- Assess the opportunity to leverage project resources through cooperation with other donors.

APPENDIX 2

Loi Fixant les Principes Généraux Relatifs à la Santé Publique en République Centrafricaine

L O I N°

FIXANT LES PRINCIPES GENERAUX RELATIFS A LA SANTE PUBLIQUE EN REPUBLIQUE CENTRAFRICAINE

L'ASSEMBLEE NATIONALE A DELIBERE ET ADOPTE,

LE PRESIDENT DE LA REPUBLIQUE, CHEF DE L'ETAT PROMULGUE LA LOI DONT LA TENEUR SUIT :

Art. 1er : Tout Citoyen a droit à la Santé.

Art. 2 : Il dispose du libre choix du praticien.

Art. 3 : Les droits visés aux articles 1 et 2 ci-dessus sont assujet à la participation financière du Citoyen pour les différent prestations de santé qui lui sont proposées par l'ensemble formations sanitaires publiques.

Art. 4 : Le Gouvernement définit la politique générale, fixe l'organi tion et le fonctionnement des services publics et privés de s et veille à la mise en application des mesures destinées à as rer la protection, le rétablissement, l'amélioration de la sa des populations, ainsi que la promotion sociale des individus des groupes sociaux composant la Communauté Nationale.

Art. 5 amendé : Afin de garantir le fonctionnement régulier des établissement du secteur public, leur gestion sera assurée soit dans le cad normal du régime financier du secteur public, soit en autonom partielle de gestion.

Art. 6 amendé : Les tarifs appliqués pour l'ensemble des prestations pratiqué dans les établissements du secteur public sont fixés dans le d'une loi.

Art. 7 : Pour le paiement des dépenses de santé, la pratique du tiers payant est autorisée.

A cet effet, des Conventions pour la prise en charge de frais de santé des salariés du secteur privé ou para-public p ront être passées entre d'une part :

- Le Département chargé de la Santé Publique et d'autre part :
  - Les Sociétés et Entreprises Privées
  - Les Sociétés Para-Publiques
  - Les Groupements de Sociétés
  - Les Associations de protection sociale à vocation mutu

Art. 8 : Les Fonctionnaires et Agents de l'Etat, leurs familles et les tres catégories socio-professionnelles participent aux dépense santé selon une proportion qui sera définie par Decret pris en seil des Ministres.

Art. 9 : L'Etat prend en charge les dépenses de santé des malades re
assistés spéciaux. Seul le malade titulaire d'une carte d'as
sociétaire peut bénéficier de la prise en charge ;

La délivrance de cette carte étant de la compétence d
des Collectivités locales suivant les critères de la régl
mentation en vigueur.

L'Etat définit le montant de la contrepartie à la char
des Collectivités locales.

Art. 10 amendé : Les recettes perçues au titre des consultations, des actes m
des actes chirurgicaux et des examens complémentaires pratiq
dans les établissements publics donnent droit au versement d
'quote-part au profit des praticiens et leurs assistants.

Les conditions de répartition et d'attribution sont fi
par Décret pris en Conseil des Ministres.

Art. 11 : L'exercice de la Médecine à titre privé peut être autorisé a
Médecins et Chirurgiens-Dentistes Fonctionnaires en dehors d
normales de service ou de permanence.

Art. 12 amendé : Est formellement interdit à le Chirurgien de
la fonction de Pharmacien dans un
blissement public avec la qualité de propriétaire ou gérant
cine ou laboratoire privé.

Art. 13 nouveau : Un délai d'un an est accordé aux Pharmaciens des établissemer
publics qui sont en même temps propriétaires ou gérants d'off
ou laboratoire privé d'opter pour la fonction publique ou le
privé.

Art. 14 : Des Décrets pris en Conseil des Ministres fixeront les
d'application de la présente Loi.

Art. 15 : La présente Loi qui abroge toutes dispositions antérieu
res sera enregistrée et publiée au Journal Officiel de la Rép
Centrafricaine./-

Fait à Bangui, le

André KOLINGBA

APPENDIX 3

Projet de Décret no. 90 Portant Tarification des Prestations des Etablissements Publics de Santé en République Centrafricaine

Projet de DECRET No 90 /
PORTANT TARIFICATION DES PRESTATIONS
DES ETABLISSEMENTS PUBLICS DE SANTE
EN REPUBLIQUE CENTRAFRICAINE

LE PRESIDENT DE LA REPUBLIQUE,

CHEF DE L'ETAT

VU la Constitution du 28 Novembre 1986,

VU la Loi 89.003 du 03 Mars 1989, fixant les principes généraux relatifs à la Santé Publique en République Centrafricaine,

VU la Loi 90.001 du 23 Février 1990, arrêtant le Budget de la République Centrafricaine pour l'Exercice 1990,

VU l'Ordonnance 73.034 du 9 Novembre 1973, portant modification et complétant les dispositions des Ordonnances 70.063 et 73.075, et son modificatif subséquent,

VU l'Ordonnance 73.033 du 15 Décembre 1973, fixant le nouveau tarif de remboursement des frais de traitement, le montant des honoraires médicaux et règlementant l'exercice rémunéré de la clientèle privée en République Centrafricaine et son modificatif subséquent,

VU l'Ordonnance 80.034 du 26 Juillet 1980, portant garanties fondamentales accordées aux fonctionnaires de la République Centrafricaine,

VU le Décret 85.059 du 5 Mars 1985, portant organisation et fixant les attributions du Ministère de la Santé Publique et des Affaires Sociales,

VU le Décret 89.145 du 28 Juin 1989, portant réorganisation du Ministère de l'Economie, des Finances, du Plan et de la Coopération Internationale, et fixant les Attributions du Ministère,

VU le Décret 90.154 du 5 Juin 1990, portant nomination des Ministres et Secrétaires d'Etat ;

SUR PROPOSITION CONJOINTE DU MINISTRE D'ETAT DE L'ECONOMIE, DES FINANCES, DU PLAN ET DE LA COOPERATION INTERNATIONALE ET DU MINISTRE DE LA SANTE PUBLIQUE ET DES AFFAIRES SOCIALES ;

LE CONSEIL DES MINISTRES ENTENDU,

D E C R E T E

Art. Ier.- La tarification faisant l'objet du présent Décret correspond à la participation financière de la population aux différentes prestations qui lui sont proposées par les établissements publics de santé.

Art. 2.- Les prestations prévues à l'article Ier ci-dessus comportent :

- les hospitalisations,
- les consultations et actes pratiqués à titre externe.

T I T R E I - HOSPITALISATIONS

Art. 3.- Le tarif du prix de journée d'hospitalisation comprend tous les frais médicaux et chirurgicaux occasionnés par le malade pendant la durée de son hospitalisation, sous réserve des dispositions prévues à l'article 6 ci-après et à l'exception de la fourniture des médicaments.

L'alimentation des malades n'est prise en compte que dans les tarifs des Hôpitaux centraux.

Le tarif du Complexe Pédiatrique du Centre National Hospitalier Universitaire de Bangui comprend la fourniture des médicaments.

..../

Art. 4.- Le tarif du prix de journée d'hospitalisation est fixé en fonction de :

- l'importance de l'établissement,
- la spécialité du service d'hospitalisation,
- la catégorie d'hospitalisation choisie.

Art. 5.- Les catégories d'hospitalisation, déterminées par les éléments de confort, sont les suivantes :

- première catégorie : salle d'hospitalisatic un lit occupé,

- deuxième catégorie : salle d'hospitalisatic deux à trois lits,

- troisième catégorie : salle d'hospitalisati de quatre lits et plus.

Art. 6.- Le patient qui reçoit des soins, en dehors de l'affection ayant motivée sont hospitalisation, doi s'acquitter du montant de ces soins au même titre que ceux pratiqués à titre externe.

Art. 7.- Les tarifs applicables au prix de la journée d'hospitalisation sont les suivants (en francs CFA

A - Hôpitaux centraux

SERVICE	CHIRURGIE		MATERNITE		MEDECI	
clientèle / catégories	Nation.	Etrang.	Nation.	Etrang.	Nation.	Etra
Ière	4.000	12.000	3.200	10.000	2.000	
2ème	2.000	6.000	1.600	5.000	1.000	
3ème	1.000	3.000	800	2.500	500	

- Nationaux : 15.000 Francs CFA,
- Etrangers : 25.000 Francs CFA.

B - Hôpitaux régionaux et préfectoraux :

SERVICES	CHIRURGIE		MATERNITE		MEDECINE	
clientèle / catégories	Nation.	Etrang.	Nation.	Etang.	Nation.	Et
Ière	800	2.500	600	2.000	400	I.
2ème	400	1.500	300	1.000	200	
3ème	200	1.000	150	500	100	

C - Centre de santé :

Le tarif de la journée d'hospitalisation dans les Centres de Santé est de :

- Nationaux : 100 Francs CFA,
- Etrangers : 300 Francs CFA.

D - Maternités urbaines de Bangui :

Le tarif d'hospitalisation dans les Maternités urbaines de Bangui est fixé forfaitairement à 1.000 francs CFA par accouchement.

T I T R E II - CONSULTATIONS ET ACTES PRATIQUES A TITRE EXTERNE

Art. 8.- Les tarifs applicables aux consultations sont les suivants (en francs CFA) :

..../.

PRATICIEN	CODIFICATION	TARIF
Technicien Supérieur Santé	Co	500
Médecin Généraliste	CI	I.000
Médecin Spécialiste	C2	2.000
Professeur et agrégé	C3	3.000

Le tarif des consultations consécutives à une hospitalisation est de 300 francs CFA.

Art. 9.- Le tarif des certificats médicaux est fixé comme suit :

- Certificat obligatoire : I.000 francs CFA.
- Certificat spécifique : 3.000 francs CFA

Art. IO.- Le tarif des actes, pratiqués à titre externe, est à partir de la valeur de la lettre-clef correspondant à la spécialité de l'acte pratiqué, affectée d'un coefficient déterminé par la nomenclature générale des actes médicaux et chirurgicaux.

Cette nomenclature est définie par Arrêté du Ministre de la Santé Publique et des Affaires Sociales.

Art. II.- La valeur des lettres-clefs prévues à l'article IO ci-dessus est la suivante (en francs CFA):

SPECIALITE	LETTRE-CLEF	TARIF
Chirurgie	K	400
Petite chirurgie et soins	PC	300
Stomatologie et soins de de conservation dentaire	D	200
Actes pratiqués par les Sages-Femmes	SF	150
Laboratoire et anatomopathologie	B et BP	70
	B et BP	30

cours de consultation ne donnent pas lieu à cumul. Seul est retenu le Service dont le tarif est le plus élevé.

Art. I3.- Les recettes perçues au titre des consultations et actes externes pratiqués dans les établissements publi de santé, donnent droit au versement d'une quote-part au profit des praticiens et leurs assistants correspondant à 30 pour cent des recettes encaissées.

Art. I4.- Les modalités de répartition des quotes-parts sont fixées par Arrêté du Ministre de la Santé Publique et des Affaires Sociales.

Art. I5.- Le présent Décret, qui abroge toutes dispositions antérieures contraires, sera enregistré et publié au Journal Officiel de la République Centrafricaine.

Fait à Bangui, le

André K O L I N G B A .-